Reticulocyte Count Template

Patient Information

Name: _____

Age: _____

Gender: _____

Date of Birth: _____/_____/_____ **[DD/MM/YYYY]**

Patient ID: _____

Contact Information: _____

Insurance Provider (if applicable): _____

Physician Information

Referring Physician's Name: _____

Specialty: _____

Contact Information: _____

Physician's Notes/Requests: _____

Specimen Information

Collection Date: _____/_____/_____ **[DD/MM/YYYY]**

Collection Time: _____ **[HH:MM]**

Specimen Type (e.g., Blood, Bone Marrow): _____

Collection Method (e.g., Venipuncture, Capillary): _____

Patient Conditions/Medications that may affect count:

_____

Test Requested

- ☐ **Reticulocyte Count**
- ☐ **Other Hematology Tests (specify):** _____

Results

Measurement	Result	Reference Range
Reticulocyte Count (%)		
Total RBC Count		

Hematocrit (%)		
Hemoglobin (g/dL)		
Additional Measurements		

Interpretation and Comments

[Add any significant findings, interpretations, or recommendations for further testing here. Include consideration of age, gender, and clinical context.]

Lab Certification and Technician/Pathologist Information

Lab Certification Number: _____

Technician/Pathologist Name: _____

Signature: _____

Date: _____/_____/_____ [DD/MM/YYYY]

Time of Report Completion: _____ [HH:MM]

Additional Notes

[Any additional observations, comments, or contextual information relevant to the test or results.]

Patient Consent for Testing (if applicable):

I consent to the processing of my specimen for the purpose of medical diagnosis.

Patient Signature: _____

Date: _____/_____/_____ [DD/MM/YYYY]